

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 12, 2021	2021_809733_0017	007094-21	Critical Incident System

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**Licensee/Titulaire de permis**

Corporation of the City of Cornwall  
360 Pitt Street Cornwall ON K6J 3P9

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**Long-Term Care Home/Foyer de soins de longue durée**

Glen-Stor-Dun Lodge  
1900 Montreal Road Cornwall ON K6H 7L1

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

MARK MCGILL (733)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 1, 2, 8, 9, 10, 16, 17, 21, 22, 23, 24, 27, 28, 29, October 1, 2021**

**log 007094-21 (CIR: M529-000007-21) was related to an unexpected death of a resident.**

**During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses (RPNs), the Administrator. The inspector also reviewed records.**

**The following Inspection Protocols were used during this inspection:  
Hospitalization and Change in Condition**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.  
Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A resident passed away unexpectedly on a specified date. An RPN assessed the resident and then proceeded to close the door to the room, call the on-coming charge nurse and then called the family of the resident. At no time did the RPN initiate CPR. A review of the resident's chart indicated that they were a level one or full code should they be found unresponsive.

Therefore, CPR was not initiated as it was supposed to be as per the plan of care.

Sources: CIS Report M529-000007-21, interview with an RPN, record review of a resident chart. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**Issued on this 15th day of November, 2021**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**